

STATEMENT OF

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On

Insuring Bright Futures Improving Access to Dental Care and  
Providing A Healthy Start for Children

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Mr. Chairman:

I appreciate the opportunity to appear before you today to discuss the issue of dental health as it relates to Medicaid and S-CHIP. It is important to continue to evaluate the structure of benefits for both of these programs and how they relate to health care reform in general.

This morning I would like to focus on three major issues as follows.

1. First, what states are currently doing to extend dental health benefits to children and how this benefit relates to other early childhood services.
2. Second, since there is essentially an explosion of health care reform activity in the states, is important to evaluate how any particular benefit mandate relates to these new reform initiatives.
3. Third, it is important to be aware of state Medicaid spending and how it is related to other state priorities such as education.

#### DENTAL HEALTH AND EARLY CHILDHOOD

Since the enactment of the State Children's Health Insurance Program (S-CHIP) in 1997, there has been a substantial expansion of dental services. While this was an optional benefit, all states have provided some dental benefits. Clearly, the enhanced federal match and increased flexibility to tailor benefits have contributed to the success of S-CHIP benefit program. Without both of these incentives the strength of the program would be jeopardized.

Access to dental services and outcomes are better in S-CHIP than in Medicaid. Any further improvements in children's dental health must come from building on the strengths and successes of S-CHIP, and that includes both funding and flexibility. Benefit mandates, or any other attempt to make S-CHIP more like Medicaid will only serve to

thwart this progress and could ultimately erode the improvements made so far. NGA will continue to oppose federal mandates.

States are using S-CHIP to meet children's primary health care needs, including dental health services. Research has shown the S-CHIP enrollees are more likely to have a medical home and more likely to receive preventive dental care. More than half of S-CHIP children have had a dental check-up in the past 6 months and over 80 percent have a usual source of dental care.

States have been working over a number of years to try to improve access to dental care for children. There are a variety of approaches that states have been using, including those that you have heard about today from Michigan. The good news is that dental access is improving for children. Beyond dental, states are also working to meet children's primary health care needs as well as expand affordable health coverage. S-CHIP has seen a success in this area too with over 90 percent of children in the program reporting that they have a usual source of medical care. The overwhelming success of S-CHIP in improving health care coverage and outcomes is why there is unanimous support among governors for a timely reauthorization of the program.

While S-CHIP and Medicaid dental benefits are important, simply having a benefit does not necessarily mean that children receive services. This is particularly true given the shortage of dentists in many areas and more importantly the more acute shortage of pediatric dentists, especially those trained to provide services to children with special health care needs. Therefore, states have taken a more holistic approach to dental care by:

- *Promoting Education and Prevention.* Much of the disease experienced by children could be prevented with better personal care and water fluoridation. Several states have launched public awareness campaigns to educate parents and children about proper dental care and to build public support for children's oral health policy initiatives.

- *Increasing Coverage and Access.* Though many low- income children have dental coverage through Medicaid, most receive no preventive dentist visits. Many states are trying to strengthen the safety net by encouraging providers to participate in Medicaid and by including dental benefits in S-CHIP.
- *Enhancing the Dental Workforce.* Many states are trying to attract dentists to chronically underserved areas, yet the number of dentists graduating from dental school is decreasing nationally. To succeed, states are using loan forgiveness, tax credits, and other incentives and are trying to enhance dentist training to adequately address pediatric needs.
- *Improving Financing and Reimbursement.* Many providers refuse to participate in Medicaid because of the low rate at which they are reimbursed. Some states have increased provider reimbursements in Medicaid to attract new dentists as well as to bring back dentists who have stopped participating.

Investments in children's health are extremely important, but Governors are also well aware of the need to look more holistically at making investments in children's futures. This is especially true in the area of early childhood development.

Motivated by compelling child development research, impressive cost-benefit evidence, and the persistent achievement gap plaguing our nation's education system, governors are pursuing pre-kindergarten expansion, full-day kindergarten, child care quality improvement and expansion, infant-toddler initiatives, and other strategies to invest in children's learning and development from birth into the early elementary years. For example:

- New York Governor Elliot Spitzer is calling for full funding of the state's \$645 million Universal Pre-K program and for full-day kindergarten planning grants for high-need districts.
- Nevada Governor Jim Gibbons has committed \$50 million to support full day kindergarten pilot programs in at-risk schools

- Arizona's recent ballot initiative will direct \$188 million in new funds for early childhood development and health programs, in addition to a \$200 million increase for voluntary full-day kindergarten programs championed by Gov. Janet Napolitano
- Minnesota Gov. Tim Pawlenty has proposed \$4000 per child for high quality early learning programs for at-risk four year olds.

## STATE HEALTH CARE REFORM

The state of Hawaii enacted universal health care access in 1974. From that point until 2003, neither the federal government nor states made very much process in covering the uninsured. In 2003, the State of Maine enacted a comprehensive proposal with the goal of universal coverage by 2009. This was quickly followed by Vermont and Massachusetts, who enacted plans in 2006 with ambitious goals to cover all of the uninsured. What is of particular note of all three of these plans is that they were bipartisan and subsidized coverage for families up to 300 percent of the federal poverty level. It is also true that these states had relatively low rates of uninsured prior to enacting reforms. While the three states face significant challenges to implement their plans, the early success in developing a state consensus for reforms has stimulated major reforms in another 20-25 states.

There are about four states that have committed to universal coverage while another ten are developing proposals for universal access to coverage. Several others are focused on universal care for all children and many others are pursuing more incremental reforms. There are a number of common elements in these reforms as follows:

**State Coverage Extensions.** To address the problem of the uninsured, states have enacted plans or are considering proposals to increase coverage and access for many Americans. These initiatives include reforming the individual insurance market, requiring individual or employer participation in health insurance, ensuring that all individual who

are eligible for S-CHIP or Medicaid are enrolled and direct subsidies to low-income individuals.

**Connectors.** A “connector” or “exchange” model offers health coverage through a quasi-governmental authority that negotiates with health insurers to offer a minimum standard of benefits within a certain premium range. The connector pools individuals together to offer affordable, private insurance options. Most “connectors” consolidate the small group and individual markets into the pool. Many states are offering subsidies for low-income individuals to purchase health insurance through the “connector.” A choice of plans is provided and portability is a major benefit.

**Tax Incentives.** Section 125 of the IRS tax code permits tax-free deductions of health insurance premiums from workers’ paychecks, saving money for both the employer and employee. Many health reform plans are requiring employers to set up the option for their workers to deduct health insurance premiums tax-free. This option is generally paired with a “connector” model to ensure minimal administrative burdens for employers.

**Employer Mandates.** Some states have required employers to either offer insurance to all of their uninsured workers or pay a fee for each uninsured employee. The employer mandate is seen as encouraging employers to continue to offer coverage and helping to fund the coverage expansion in the state. Generally, those states requiring employer contributions are those aimed at achieving universal coverage.

**Individual Mandates.** Some states are moving toward a requirement on individuals to have health insurance coverage. Through state income tax filings, individuals who can afford coverage and are found not to have insurance will be fined. An individual mandate is being paired with mechanisms to make coverage more affordable for all residents, so individuals have the opportunity to meet the mandate without facing a financial hardship.

**Quality Improvements and Measurements.** Using coverage expansions and Medicaid redesigns as vehicles, many states have incorporated quality improvement and

measurement into their health reform plans to improve efficiency and patient care. Many states are using disease management programs, applying quality measures for doctors and hospitals, and taking steps toward interoperability with electronic data systems.

**Benefit Packages.** Here, states are negotiating with providers to make a basic benefit package available to current low-income individuals and small businesses. Some of these may be paired with health savings accounts. The benefit package is then offered through the connector.

The question now is how does a mandate for dental health or any other mandate on the Medicaid or S-CHIP benefit package relate to these reform efforts. I would argue that it could well be an obstacle in the following two ways.

- 1) Requires states to spend more money per person in these programs, which redirects funds from eligibility expansions; and
- 2) Limits state efforts to create affordable consolidated insurance markets.

The goal of state actions is universal coverage or universal access. To attain this goal, states use a combination of existing programs, including Medicaid and S-CHIP, and new mechanisms to expand affordable health insurance. If states are required to meet new federal benefit mandates in either Medicaid or S-CHIP, they will have to spend more money per individual currently covered in these programs. Efforts to enroll eligible uninsured individuals and many planned expansions of these programs will be more expensive for states. These increased costs will force states to redirect funds that could have been used to fund other affordable health insurance initiatives. Reducing flexibility in these programs is a real obstacle both to maintaining existing coverage as well as coverage expansion.

New mandates on Medicaid and S-CHIP is also a potential obstacle to state efforts to create affordable consolidated insurance markets. Most state coverage efforts include negotiation, with providers to develop basic benefit packages that would be subsidized by states and offered through the “connector.” Often this would be the same benefit package

that is offer by the managed care or other major providers, which is often the same as that provided to state employees. Essentially, the connector consolidates the small group and individual markets into a pool. It then matches providers who are offering benefits with the demand for health care by states via state employees, S-CHIP and Medicaid, as well as small business, state subsidized previously uninsured and other individuals with COBRA or similar needs.

This approach spreads risk, lowers cost, and stabilizes this market. Essentially, mandates that change this benefit package will become an obstacle to the efficiency of these pools. Rather than allow federal programs to be integrated into the health care system, S-CHIP and Medicaid will continue as separate more expensive programs.

Mr. Chairman, we urge you not to impose any additional mandates on states. Instead Congress should work with states to support current health reform efforts.

#### MEDICAID vs. OTHER DOMESTIC PRIORITIES

Governors prefer maximum flexibility in administering almost all federal programs. This allows states not only to tailor their programs to the specific needs of their citizens, but increases the efficiency of programs.

Governors and states now have about 40 years experience with Medicaid. It is the nation's critical safety net health coverage program for low-income individuals and families. It covers 40 percent of non-elderly Americans living in poverty. It also covers more than 7 million in Medicare of the almost 44 million enrollees, as well as 28 million children or 1 in every 4. Finally, it covers long-term care coverage for 8 million low-income Americans with disabilities and chronic illness. In total, the program now covers 53 million Americans and costs about \$317 billion in 2005.

Unfortunately, Medicaid has grown almost 11 percent per year over that last 25 years. It now totals 23 percent of the average state budget, more than states spend on all



elementary and secondary education. In states like Tennessee and Missouri it constitutes about 35 percent of their state budgets.

With state revenues growing only about 5-6 percent per year, Medicaid has been funded by cutting virtually all other components of state spending. The stark reality of this in terms of total state spending is as follows:

- Between 1988 and 2005, a seventeen year period, Medicaid has grown from 11.5 to 22.9 percent of state budgets. All components of state budgets have been cut to accommodate this increase.
- Elementary and secondary education went from 23.9 percent to 21.8 percent, while higher education went from 12.8 percent to 10.8 percent over the same period. The rest of the cuts came from welfare, economic development, environmental, and infrastructure programs.

Providing health care benefits to all Americans—while critical—is not the only challenge facing state governments. The new world marketplace will challenge our standard of living. The United States used to compete with high wage, high technology countries in the developed world or low wage, low technology countries in underdeveloped countries. Now the United States competes with high technology, low wage emerging nations. Some of these emerging nations are rapidly growing large countries—such as India and China—while others are the smaller Pacific Rim countries, like Taiwan, Korea, and Singapore. But this list also includes many of the nations of Eastern Europe and emerging regions in South America as they join the world marketplace.

Some of these countries compete with the United States in the production of manufacturing goods, from textiles to electronics to automobiles, while others are challenging the United States in Web construction, call centers, software development, and electronic products. Essentially, the changing world market has eliminated most safe havens where a nation's output and jobs are not threatened by increased competition.

The United States' ability to compete in this new knowledge-based highly competitive world economy will depend on its ability to innovate, which in turn depends upon the education and training of our workforce. The economic cost of not being able to innovate will be reflected in the reduction of real wages and real incomes of United States citizens. This may not lead to any crisis in the short term, but reductions in real wages of 1-2 percent a year over the next decade can have a dramatic impact, particularly on low and middle income Americans. Further, reductions in this standard will create tensions among the various groups and societal institutions.

While the United States has witnessed cyclical downturns when real wages have fallen, the trend over the last 200 years has generally been upward. The choice going forward, however, is between reductions in real wages or accelerating the rate of innovation. It is not possible to reestablish trade barriers to protect our current standard of living.

In order to compete in the new emerging global marketplace, we have to dramatically upgrade the education and training of our labor force. To date, our education performance has been less than stellar.

- U.S. 15 year-olds ranked 24 out of 39 countries on the Program for International Student Assessment (PISA) of students' ability to apply mathematical concepts to real world problems.
- In 2004, the U.S. produced 137,000 new engineers while India provided 112,000 and China produced \$352,000 adjusted for quality.

Mr. Chairman, at this time states spend about one-third of their revenues on health care and about one-third on education. However, the double digit growth in state health care spending may not be sustained in the future. If the past is a good indication of the future, it would be financed by cuts in education. Future cuts in education, however, will lead to declines in our standard of living.

Health care and education are our two major domestic challenges as we go forward as a nation. It is important to have universal health care or universal access. But it is also important to increase our standard of living, which requires additional spending on education. Governors are attempting to find the appropriate balance between these two challenges.